Government of Saskatchewan

Annual Report 1987-88

Saskatchewan Health Prescription Drug Plan

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To The Honourable Sylvia Fedoruk,
Lieutenant Governor of Saskatchewan

May it please Your Honour:

In accordance with Section 8(3)(e) of The Prescription Drugs Act, I am pleased to present the Annual Report of the Prescription Drug Plan for the period of April 1, 1987 to March 31, 1988.

Respectfully submitted,

George McLeod,
Minister of Health

George McLeod,
Minister of Health

To The Honourable George McLeod,
Minister of Health

Sir:

I am pleased to present herewith the Annual Report of the Prescription Drug Plan for the fiscal year ending March 31, 1988.

Respectfully submitted,

Stan Sojonky,
Deputy Minister
of Health

Stan Sojonky,
Deputy Minister
of Health

Michael Shaw,
Associate Deputy
Minister of Health

R. J. (Ron) Waschuk,
Executive Director,
Prescription Drug Plan

Objectives of the Prescription Drug Plan

The Prescription Drug Plan was established to:

1. Reduce the direct cost of prescription drugs to Saskatchewan residents.
2. Provide coverage to Saskatchewan residents for quality pharmaceutical products of proven therapeutic effectiveness.
3. Reduce the cost of drug materials by encouraging effective price competition and quantity discounts.
4. Encourage the rational use of prescription drugs through research, consultation with professional associations, and educational programs directed at physicians, pharmacists and the general public.

History

1. The Prescription Drug Plan began providing benefits on September 1, 1975.
2. In addition to drugs listed in the formulary, certain drugs are covered by "exception status" if specific criteria are met.
3. Since January 1976, some nutritional products have been covered where specific criteria have been met.
4. As of April 1981, the Prescription Drug Services Branch became the paying agent for the Medical Services Division (MSD) and Saskatchewan Aids to Independent Living (SAIL). Payment is made to pharmacies for non-formulary prescription drugs that are benefits to specific clients of these agencies.
5. Liquid and gaseous oxygen benefits were transferred to the Saskatchewan Aids to Independent Living program on July 22, 1987.
6. On July 1, 1987, the Prescription Drug Plan changed from a fixed co-payment coverage program to a basic deductible and co-payment program, except for those residents entitled to special health benefits.

Historical Background to the Prescription Drug Plan

The Prescription Drug Plan was designed in consultation with physicians, pharmacists and pharmaceutical wholesalers.

Some of those major design criteria at implementation were:

1. The consumer should pay a portion of the prescription cost.
2. A drug formulary system should be used. Only drugs proven to be therapeutically effective and made by competent manufacturers should be eligible for coverage.
3. The existing wholesale and pharmacy retail distribution systems should be used.

The enabling legislation for the Prescription Drug Plan, The Prescription Drugs Act, was assented to on May 10, 1974.

The Plan in Brief

All Saskatchewan residents who hold valid Saskatchewan Health Services Cards, except those who have prescription costs paid by another federal or provincial government agency, are eligible to receive benefits of the Prescription Drug Plan.

Drugs eligible for coverage must be prescribed by a licensed physician or dentist and must be listed in the most current edition of the Saskatchewan Formulary.

The range of drugs listed in the Formulary enables physicians to select appropriate courses of therapy for most patients. Drugs are under continual review, and additional drugs may be added to the Formulary if recommended by the Saskatchewan Formulary Committee.

Consumers exempted from the deductible program pay no more than $3.95 for each prescription for drugs covered under the Prescription Drug Plan. This level is unchanged since 1984.

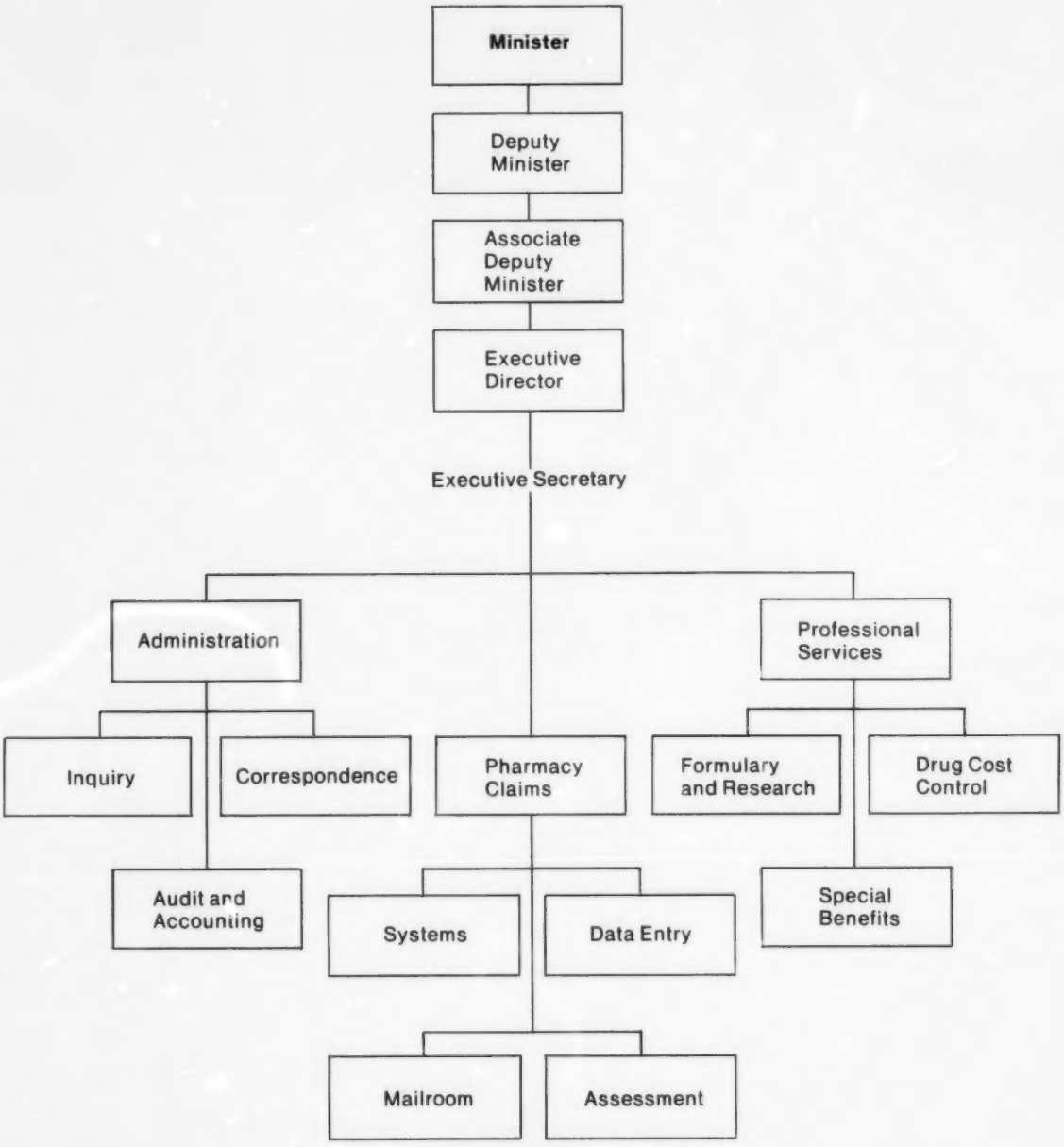
Beneficiaries eligible under the deductible program pay the entire prescription cost at the time of purchase. Claims may be submitted to the Prescription Drug Plan for 80% reimbursement of approved costs in excess of the deductible level.

The Prescription Drug Services Branch provides personnel and financial support to the Saskatchewan Formulary Committee, the Drug Quality Assessment Committee, and the Joint Committee on Drug Utilization.

Highlights for 1987-88

- Ninety-five percent of Saskatchewan residents were entitled to benefits under the Prescription Drug Plan.
- On average, 11.7 prescriptions were dispensed to each active beneficiary exempt from the deductible program.
- On average, 11.9 prescriptions were dispensed to each family unit under the deductible program.
- The Prescription Drug Plan made reimbursements to family units at an average of $145.98 per family.
- The Prescription Drug Plan paid an average share of 60.1% of the total prescription costs under the deductible program.
- There was 3.9 million prescriptions processed during the fiscal 12 month period.
- Net Prescription Drug Plan payments for formulary drugs and exception status drugs were $57.7 million during the fiscal 12 month period.
- 77 new products were added to the Saskatchewan Formulary bringing the total number of drug products listed to 1818.
- Two editions of the Saskatchewan Formulary Bulletin were released during the year. These presented information about new products added to the Formulary.
- In consultation with the Saskatchewan Pharmaceutical Association, it was agreed, effective July 1, 1987, to raise the dispensing fee for drugs from $5.49 to $5.50. To better relate the earnings of pharmacy to that of general business practice, it was also agreed to discontinue payment of an inventory cost allowance, and to establish allowable mark-ups.
- A new Palliative Care Program was introduced. For the first time ever, terminally ill patients are provided with Formulary drugs at no charge.
- The maximum allowable dispensing fee under the deductible program was $5.50. The average on claims submitted for reimbursement was $5.19.
- The average drug cost in a prescription was $13.79 during the first quarter under the first dollar program, and $13.41 for the last three quarters under the deductible program.
- During the year, through the Prescription Drug Plan, the Department of Health provided funding for:
  a) the Roving Professorship Program which brought information on current drug therapy to physicians in smaller communities throughout the province.
  b) the Dial Access Drug Information Service, a province wide drug information service for health professionals.
- Information from the data base has been used to fulfill research requests from a variety of sources.

Organization of the Saskatchewan Prescription Drug Plan



Administrative Organization

On October 6, 1986, the Prescription Drug Services Branch reorganized to consolidate the previous five divisions into three.

The Contracts Division, Formulary and Education Division, and the Research Services portion of the Program Evaluation Division were amalgamated into a Professional Services Division. The statistics portion of Program Evaluation was incorporated into the Administration Division.

Executive Director

The Executive Director is responsible for the overall management of the Prescription Drug Services Branch. The Executive Director serves as principal contact on matters of policy and procedures with representatives of pharmacy, medicine, drug wholesalers and drug manufacturers, as well as related sectors in other provincial governments and the federal government, and other agencies with health care involvement.

Administration Division

The Administration Division is responsible for: developing and implementing the administrative policies and procedures; maintaining the Drug Plan data base; specification and production of statistical information; and preparation of the Annual Report.

Functions include: budget preparation and monitoring; space, property and supply management; pharmacy audit; processing of revenue accounts and expenditures (excluding pharmacy claims); ensuring families and pharmacies receive payment; processing of manual claims payment; preparation of reports, materials and financial data for year end statements; other miscellaneous administrative functions.

The Division provides support services to other Branch functions, including personnel management; team typing, and space co-ordination.

The Audit Section conducts post-audits of pharmacy claims to ensure compliance with the Pharmacy Proprietor/Province of Saskatchewan Agreement.

Pharmacy Claims Division

The objectives of the Pharmacy Claims Division are to: provide accurate and prompt payment; maintain efficient and cost-effective operation and processing; maintain credibility with pharmacists and family beneficiaries.

The Pharmacy Claims Division is responsible for the processing and payment of accounts submitted by participating pharmacies and eligible families. These accounts are submitted via paper claims or telecommunication.

Computer services necessary for the processing of claims are co-ordinated by this Division and supplied by Westbridge Computer Corporation and Saskatchewan Health.

Processing and payment of pharmacy claims involves the combined efforts of several sections in the Pharmacy Claims Division. The Systems Section provides analysis and detail design for changes to manual and computer processing of claims. This section also has responsibility for systems control measures, implementation and testing.

The Processing Section is made up of three units. The Mail Services Unit receives and screens incoming claims. The Data Entry Unit transfers the information from these claims to magnetic tape to enable computer processing of accounts. Routine assessments and approval of accounts for payment are performed by computer. Each claim is checked against stored information to determine whether it can be approved for payment. Claims which are not approved for payment are rejected for manual review. Those which require correction, clarification or interpretation are sent to the Assessment Unit.

The Pharmacy Claims Division is responsible for communication with pharmacies regarding Prescription Drug Services Branch operations. The division issues periodic bulletins to pharmacies and maintains the Pharmacy Manual. These items provide pharmacies with current statements of Branch policies and procedures.

Professional Services Division

The Professional Services Division is responsible for all matters related to the selection, assurance of quality, acquisition and review of use of all drugs covered by the Prescription Drug Plan. It is also responsible for communications with consumers, prescribers and pharmacists in matters related to informed, responsible drug use.

This division is comprised of three units, the Formulary and Education Unit, the Drug Utilization Unit, and the Special Benefits Unit.

Functions of the Formulary and Education Unit include: providing support services to the Drug Quality Assessment Committee and the Saskatchewan Formulary Committee in the review of products under consideration for listing in the Formulary; evaluation of drug costs and preparation of use/cost analysis reports; forwarding recommendations of the Saskatchewan Formulary Committee regarding listing of products, and designation of interchangeable status; publishing and distribution of the Saskatchewan Formulary; ensuring that pharmacies have available to them a continuous supply of quality drugs at reasonable prices; arranging for the acquisition and distribution of drug products listed in the Saskatchewan Formulary by tendering of Standing Offer Contracts

for commonly used products and establishing Maximum Allowable Costs in other cases; ongoing surveillance of manufacturers to ensure compliance with acceptable standards of manufacturing practice; and encouraging rational use of drugs by developing and supporting education programs and services for consumers, physicians and pharmacists.

The Drug Utilization Unit provides support services to the Joint Committee on Drug Utilization. These include research into the use of drugs, comparison of Saskatchewan data with reports of studies in other areas, and preparation of background information for review by the Committee.

The Unit initiates, directs, and coordinates research projects using Prescription Drug Plan claims data. These projects include in-house drug-use studies and international multi-sector collaborative research projects. The unit administers the Branch policy and program for release of information, providing assurance that all requirements for confidentiality are met.

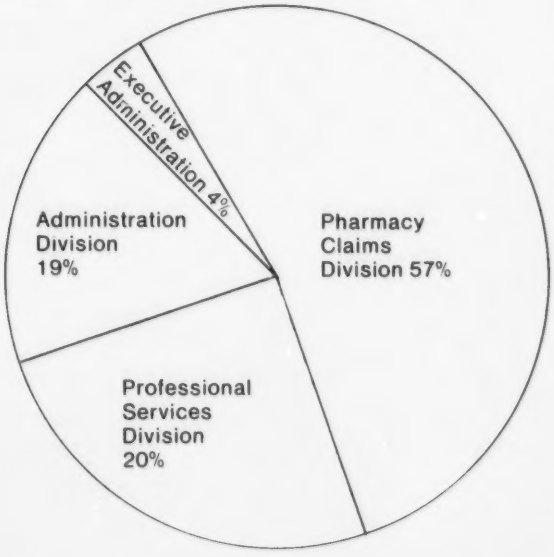
This Unit is also responsible for the provision of advisory or consultative services to other Saskatchewan Health Branches and outside agencies in matters related to drug use and/or pharmacy services.

The Special Benefits Unit reviews requests from physicians and evaluates and authorizes special categories of drug coverage (for example, Exception Drug Status, Saskatchewan Assistance Plan Two coverage, Palliative Care) when appropriate.

This Unit is also responsible for administering the Special Drug Cost Coverage program by receiving applications from beneficiaries, reviewing and costing the applications, and communicating the recommendations of the Drug Benefits Review Panel.

Administrative Disbursements

Figure 1. Administrative Disbursements



The total administrative costs for the fiscal year are separated by Division in the figure above. The percent allocated to each Division is indicated. The figure illustrates that 23% of these disbursements (approximately 1% of total program costs) are used to administer the program, and that 20% of the disbursements are used to support activities related to assurance of quality and encouragement of the rational use of prescription drugs. For ease of discussion the Divisions and their general functions appear to be distinct. However, the overall efficiency of the Prescription Drug Plan depends on interdependence of the Divisions within the Branch.

Benefits of the Prescription Drug Plan

With the exception of insulin and diabetes urine testing agents, a prescription from a physician or dentist is required for all drugs covered under the Drug Plan.

These drugs include all products listed in the Saskatchewan Formulary and certain products granted Exception Drug Status for specific individuals.

Formulary Drugs

All drugs listed in the most current edition of the Saskatchewan Formulary are covered under the Prescription Drug Plan.

Exception Drug Status

Drugs not listed in the Saskatchewan Formulary may be covered by the Prescription Drug Plan as "exception drugs" if one of the following criteria is met:

1. The drug is ordinarily administered only to hospital in-patients but is being administered outside of a hospital because of unusual circumstances;
2. The drug is not ordinarily prescribed or administered in Saskatchewan, but is being prescribed because it is required in the diagnosis or treatment of an illness, disability, or condition rarely found in this province;
3. The drug is infrequently used because formulary preparations are usually effective, but are contraindicated or found to be ineffective due to the clinical condition of the patient;
4. The drug has been deleted from the Formulary but continues to be required by patients previously stabilized on the drug;

Requests for Exception Drug Status must be made by a physician or dentist. Requests may be mailed or telephoned. A 24 hour toll-free prescriber-line is provided by the Prescription Drug Services Branch.

Patients granted such coverage are provided with an authorization card to be presented when obtaining the drug.

Patients are responsible to pay the full cost or the normal prescription charge, just as they would for drugs listed in the Saskatchewan Formulary.

Nutritional Products

Saskatchewan Health provides assistance with the cost of some nutritional products when certain disease states prevent the use of normal foods. Requests for assistance must be made by a physician and supported by a dietician's report.

Administration of these benefits was transferred from the Prescription Drug Services Branch to the Community Health Services Branch on October 1, 1987.

Medical Oxygen

Medical oxygen is a benefit under Saskatchewan Health. Administration of this program was transferred from the Prescription Drug Services Branch to the Community Health Services Branch on July 22, 1987.

Products for Diabetics

Persons with diabetes may obtain insulin, urine testing agents, blood glucose testing agents and oral hypoglycemics as benefits under the Prescription Drug Plan, if those products are listed in the Saskatchewan Formulary.

In order to receive coverage, diabetics require a prescription for blood glucose testing agents and oral hypoglycemics, but not for insulin or urine testing agents.

Diabetics, for each prescription charge, are entitled to receive up to a 100-day supply of oral hypoglycemics or up to a 34-day supply of blood glucose testing agents. A reduced prescription charge of $1.00 is applied to each package of insulin or urine testing agent. A charge of 20% of the total prescription cost is applied to the purchase of each blood testing agent.

Over-The-Counter-Products

With few exceptions, over-the-counter (OTC) products are not included as benefits of the Prescription Drug Plan.

Special Drugs

Effective July 1, 1987, the Prescription Drug Plan provides coverage for the full cost, paid directly to the pharmacy, of certain rarely used drugs which are extremely expensive. Examples include Cyclosporin (used to prevent rejection following organ transplant) and AZT (used to treat A.I.D.'s patients).

The Saskatchewan Formulary

The Prescription Drug Services Branch prepares and maintains the Saskatchewan Formulary. The Formulary serves as the list of products covered by the Prescription Drug Plan and as the Interchangeable Drug Index (IDI). Only those products meeting established criteria for high quality and therapeutic effectiveness are considered for listing.

Drugs listed in the Formulary are under continual review and additions and deletions are recommended when necessary. A revised edition of the Formulary is published on January 1 and July 1 of each year. The Saskatchewan Formulary Committee is the major resource toward preparation of the Formulary.

The unit drug material cost appears in the Formulary for those products where a Standing Offer Contract (SOC) is awarded. All other products are listed in descending order of manufacturers quotes, as Maximum Allowable Cost (MAC) for the smallest package size available commercially.

Saskatchewan Formulary Committee

The Saskatchewan Formulary Committee is appointed by the Minister of Health to provide advice in the compiling and maintaining of the Saskatchewan Formulary.

The Committee also identifies those products which are "interchangeable". Interchangeable products are different brands of the same drug with the same strength and equivalent dosage form. They are equivalent in therapeutic effectiveness and quality.

Part of the Committee's ongoing work is to review new drug products and to re-evaluate listed products in light of new information on their use and effects.

The Prescription Drug Services Branch provides resources and staff support to the Committee.

Members of the Saskatchewan Formulary Committee as at March 31, 1988 were:

Mrs. E. MacPhail _____ Chairperson

Dr. D. R. Amies _ Saskatchewan Medical Association

Mrs. E. Bayda _____ Saskatchewan Registered Nurses' Association

Dr. M. W. Davies _____ Saskatchewan Medical Association

Dr. G. E. Johnson — College of Medicine
Dr. A. J. Remillard — College of Pharmacy
Mr. N. Shevchuk — Saskatchewan Pharmaceutical Association
Dr. R. West — Saskatchewan Health
Mr. M. Wolfe — Saskatchewan Health-Care Association

Drug Quality Assessment Committee

The Drug Quality Assessment Committee is appointed by the Minister of Health to advise and assist the Saskatchewan Formulary Committee. The members of this committee are knowledgeable in the clinical use of drugs, pharmacology, and drug manufacturing.

This Committee reviews drug products based on information and reports obtained from manufacturers and independent consultants, manufacturing documents and published literature. Representatives of the Committee periodically visit manufacturing facilities to assess production methods and capabilities. Recommendations regarding the clinical effectiveness and quality of products are then submitted to the Saskatchewan Formulary Committee.

The Prescription Drug Services Branch provides resources and staff support to the Committee.

Members of the Drug Quality Assessment Committee as at March 31, 1988 were:

Dr. G. E. Johnson — Chairman
Dr. R. Herman — Clinical Pharmacology
Dr. I. Holmes — Internal Medicine
Dr. A. J. Remillard — Clinical Pharmacy
Dr. A. E. Somerville — Internal Medicine
Dr. T. W. Wilson — Clinical Pharmacology
Dr. D. Zuck — Pharmaceutics
Mrs. E. MacPhail — Ex-Officio Member

Joint Committee on Drug Utilization

The Joint Committee on Drug Utilization is appointed by the Minister of Health to consider quality of care issues as they pertain to drug use. The Committee's terms of reference are as follows:

1. To identify areas of concern related to drug utilization.
2. To carry out study and analysis related to the concerns identified.
3. To recommend appropriate methods of dealing with concerns related to drug utilization and its impact on the quality of care.
4. To provide information that can be used in educational programs for the public and the health professions.

The Committee may make recommendations to the Minister of Health or to the professional and regulatory bodies represented on the Committee.

The Prescription Drug Services Branch provides resources and staff support to the Committee.

Members of the Joint Committee on Drug Utilization as at March 31, 1988 are:

Dr. J. Blackburn — Chairman College of Pharmacy
Dr. W. L. Albritton — College of Medicine
Dr. T. A. Wigmore — College of Physicians and Surgeons
Dr. J. D. Coucill — Saskatchewan Medical Association
Mr. G. Groves — Saskatchewan Pharmaceutical Association
Ms. H. Durdin — Saskatchewan Registered Nurses' Association
Mr. T. Quinn — Prescription Drug Services Branch

Eligibility for Coverage

Saskatchewan residents registered with Saskatchewan Health are eligible for benefits under the Prescription Drug Plan unless their drug costs are assumed by another federal or provincial government or non-government agency.

Exclusions from Coverage

The following categories of persons are not eligible for Prescription Drug Plan coverage because coverage is provided by other agencies:

1. Registered Indians (federal government responsibility)
2. Department of Veterans Affairs beneficiaries (federal government responsibility)
3. Royal Canadian Mounted Police (dependents are covered by the Prescription Drug Plan)
4. Canadian Forces Personnel (dependents are covered by the Prescription Drug Plan)

Consumer Cost Share

Prior to July 1, 1987 consumers paid a maximum of $3.95 for each prescription for most drugs covered by the Prescription Drug Plan and a maximum of $1.00 per package for insulin and urine testing agents. The balance of the total prescription cost was paid by the Prescription Drug Plan.

On July 1, 1987 a deductible provision was introduced, where most consumers paid the full cost of most drugs covered by the Prescription Drug Plan, and then submitted claims for an 80% reimbursement of amounts over a deductible. Certain consumers were exempted from deductibility. These consumers are Special-Care Home Residents and Social Assistance Recipients. Two other groups were also given special consideration. For the first time, those consumers in Palliative Care, once approved, obtain Formulary drugs at no cost. Those with high drug cost and approved by the Drug Benefits Review Panel are granted certain privileges to purchase prescriptions upon up-front payment of 20% of the total prescription cost.

Saskatchewan Assistance Plan Beneficiaries

Residents receiving benefits through the Saskatchewan Assistance Plan are entitled to Prescription Drug Plan benefits at a reduced prescription charge, or at no charge depending on their level of coverage.

a. **Plan One Coverage**

Plan One beneficiaries 18 years or older are entitled to receive insulin, oral hypoglycemics, injectable vitamin B_{12}, allergenic extracts, oral contraceptives and some products used in megavitamin therapy at no charge. These beneficiaries pay a reduced prescription charge, to a maximum of $2.00, for all other Formulary drugs and Exception Drug Status products. Prior to 1984, this charge was $3.95.

Beneficiaries under 18 are entitled to receive all formulary drugs, allergenic extracts, megavitamins and approved Exception Drug Status products at no charge.

b. **Plan Two Coverage**

Beneficiaries receiving Plan Two coverage are entitled to receive all formulary drugs, allergenic extracts, megavitamins and approved Exception Drug Status products at no charge.

Plan Two coverage is provided to assist Plan One beneficiaries who require several drugs on a regular long-term basis. Eligibility for Plan Two coverage is determined on the basis of a physician's review of medication requirements.

c. **Plan Three Coverage**

Plan Three beneficiaries are entitled to receive all formulary drugs and certain non-formulary drugs at no charge. Non-formulary drugs are covered by the Medical Services Division (M.S.D. also covers the cost of megavitamins and allergenic extracts for Plan One and Plan Two beneficiaries.)

Plan Three beneficiaries are Saskatchewan Assistance Plan recipients who live in Special-Care homes licensed under The Housing and Special-Care Homes Act, Approved Homes licensed under The Mental Health Act, and Wards of the province.

S.A.I.L. Beneficiaries

Saskatchewan Aids to Independent Living (S.A.I.L.) pays for all non-formulary disease-related drugs used by Special Beneficiaries nominated by S.A.I.L. Special Beneficiaries include paraplegics, persons with cystic fibrosis or persons with chronic end-stage renal disease.

These beneficiaries are entitled to receive all prescribed formulary drugs and disease-related non-formulary drugs at no charge.

Special-Care Home Residents

For residents of Special Care homes licenced by the Department of Health under the Housing and Special Care Homes Act, the deductible does not apply. These beneficiaries continue to receive eligible prescriptions for a fixed maximum co-payment of $3.95.

Palliative Care Program

For persons registered under the Palliative Care Program of the Prescription Drug Services Branch, the deductible does not apply. Prescriptions for eligible drugs are provided to them at no charge, a new benefit first introduced in 1987.

Special Drug Benefits

Through the Drug Benefits Review Panel, a mechanism exists to enable the review of situations where families or individuals may experience difficulty in meeting payment obligations under the Drug Plan. The three member panel is comprised of representatives of the College of Physicians and Surgeons of Saskatchewan, the Saskatchewan Pharmaceutical Association, and the Saskatchewan Department of Health. Members are appointed by the Minister of Health.

Based upon review of information provided by applicants, the Panel may recommend and make available additional assistance.

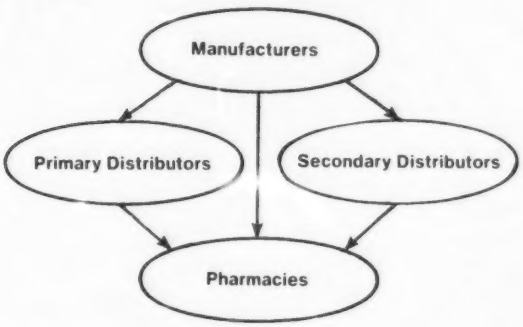
Paying Agency

The Prescription Drug Services Branch functions as a paying agency for M.S.D. and S.A.I.L. for those additional benefits provided to Saskatchewan Assistance Plan beneficiaries and Special Beneficiaries.

The appropriate costs are subsequently recovered from M.S.D. and S.A.I.L. by the Prescription Drug Services Branch.

Drug Acquisition and Distribution Network

A continual supply of quality drugs at competitive prices is ensured using the following distribution network:



Distributors purchase drug products from manufacturers and sell them to pharmacies. Pharmacies may also purchase directly from the manufacturer.

As of March 31, 1988, there were four (4) distributors serving the province, three primary and one secondary.

Pricing Formulary Products

In order to ensure price stability for the six month effective Formulary period, the Prescription Drug Services Branch requires drug manufacturers to provide guaranteed maximum prices for the period. The Formulary periods are from January 1 to June 30 and July 1 to December 31 of each year. The prices constitute the maximum the Prescription Drug Plan will pay for those products during the effective Formulary period.

Standing Offer Contracts (S.O.C.) are obtained on certain high volume products.

An S.O.C. is a contract between a manufacturer and the Prescription Drug Services Branch to supply specific drug products to approved distributors at a contracted price.

The S.O.C. contract may not always go to the lowest bidder or to a single supplier. Other factors, including an allowance to the previous contract holder, ability to meet supply and distribution commitments, and innovator allowance are taken into account.

Once an S.O.C. has been granted, the Prescription Drug Plan will only pay for the S.O.C. drug in an interchangeable category unless the prescriber has specified "no-substitution".

Participating Pharmacies

All pharmacies providing benefit services of the Prescription Drug Plan must sign an Agreement with Saskatchewan Health. Pharmacies close to our borders but in Alberta and Manitoba are also eligible to participate. Saskatchewan physicians in remote communities without pharmacy services may participate by signing the Agreement and obtaining pharmacy licensure with Saskatchewan Pharmaceutical Association.

At March 31, 1988, there were 371 pharmacies delivering Prescription Drug Plan covered services. This figure includes 324 retail outlets in the province, 33 in Alberta and Manitoba and 14 dispensing doctors within the province.

Pharmacy Reimbursements

According to the July 1987 — June 1988 Agreement between Saskatchewan Health and pharmacy Proprietors, the pharmacy receives its acquisition cost of drug material, along with a mark-up plus a dispensing fee for each prescription.

The dispensing fee up to June 30, 1987 varied depending on the volume of prescriptions dispensed by the pharmacy. The dispensing fee was $5.49 for the first 15,000, $5.23 for each prescription in excess of 15,000 but not exceeding 25,000 prescriptions and $4.80 for each prescription in excess of 25,000. Consumers paid a maximum of $3.95 as their portion of total costs. The Prescription Drug Plan paid the pharmacy the balance of the dispensing fee, the pharmacy's acquisition cost of the drug material, and an inventory cost allowance. The inventory cost allowance was paid to June 30, 1987 on a per paid claim basis. The inventory cost allowance was $0.4624 per paid claim at June 30, 1987.

For insulin and urine testing agents, the Prescription Drug Plan pays the pharmacy the cost of the drug material, plus a percentage markup (33 1/3% for insulin, 50% for urine testing agents), less the maximum consumer charge of $1.00 for these products.

Between April 1, 1987 and March 31, 1988, the Prescription Drug Plan paid a total of $57.7 million for Formulary and Exception Status Drug prescriptions.

The dispensing fee was increased on July 1, 1987 to $5.50 with no reduction depending on volume. A mark-up provision was implemented to replace the inventory cost allowance. The mark-up allowance is calculated on the drug cost in the prescription as follows: 30% for drug cost up to $4.99, 15% for drug cost between $5.00 and $12.49, and 7% for drug cost of $12.50 and over.

Beginning July 1, 1987, consumers pay the pharmacy for the full cost of the prescription, and then submit claims to the Drug Plan for an 80% reimbursement of amounts over a deductible.

Consumers exempted from the deductible program continued, as they did prior to July 1, 1987, to pay a maximum of $3.95 as their portion of the total prescription cost. The Pharmacy, for these consumers, continued as in the past to submit claims to the Prescription Drug Services Branch to recover the balance of the costs of the prescription.

Prescription Quantities

The Prescription Drug Plan does not limit the quantities of drugs a physician may prescribe. Physicians determine the course and duration of treatment for their patients, limited only by regulations governing the practice of pharmacy.

The Prescription Drug Plan, however, shall not pay for more than a six-month supply of drugs at one time.

Product Interchangeability

The Saskatchewan Formulary Committee has identified approximately 300 interchangeable drug groups. Interchangeable products are different brands of the same drug with the same strength and dosage form, and equivalent in therapeutic effectiveness and quality.

When a prescription is filled for a drug in an interchangeable category, payment is usually based on the lowest-priced product in that category. For example, if an interchangeable group contains the following brands at the unit prices shown:

Brand 1	$0.0180
Brand 2	0.0190
Brand 3	0.0235
Brand 4	0.0235
Brand 5	0.0252
Brand 6	0.0410

and the physician prescribes any brand in this category, the pharmacist will be reimbursed for the drug dispensed to a maximum of 1.8¢ per unit for those claims submitted to the Drug Plan. If, however, Brand 1 has a Standing Offer Contract, the Prescription Drug Plan will not reimburse the pharmacy unless that brand was dispensed. If a prescription is ordered for any brand other than the low-cost brand listed, and is supported by a "no-substitution" order from the prescriber, reimbursement will be based on the costs of the brand so ordered.

If the prescriber indicates "no-substitution", the Prescription Drug Plan will pay for the brand specified. If, for example, the prescription was written for Brand 6, "no-substitution", the pharmacist would dispense Brand 6 and reimbursement would be based on the cost of up to 4.1¢ per unit.

Claims Processing

The Prescription Drug Services Branch provides pharmacies and consumers with specially designed forms for the purpose of submitting accounts (claims). Pharmacies with computers have the option of submitting their claims through direct telecommunication linkage.

All claims are checked to ensure completeness. Claims information is then keyed onto magnetic tape in preparation for issuing payments.

Before an account can be approved for payment, each claim is computer checked against the stored drug eligibility and cost, and patient eligibility.

In the fiscal year ending March 31, 1988, 3.9 million* prescriptions were processed for formulary and exception status drugs.

Data Base Information

The Prescription Drug Services Branch has established policies and guidelines governing access to and use of data base information. These policies and guidelines are necessary to protect the confidentiality of patient information.

All requests for such information must be in writing and addressed to the Executive Director of the Prescription Drug Services Branch.

* prescriptions filled for patients in the deductible program (after July 1, 1987), but who did not exceed their deductible, are not claimed. These are therefore not recorded by the Drug Plan, explaining the reduced count compared to previous years.

Statistical Synopsis

Prescription Drug Plan Beneficiaries

The Prescription Drug Plan data base on July 1, 1987 changed to a family basis from the previous beneficiary basis because claims processed under the deductible system are by family unit. With this change to family unit, claims information about age, sex, prescriber, pharmacy volume, and manufacturer volumes became non-comparable to previous years.

Eligible Population (At June 30, 1987)

A total of 990,924 individuals, within 500,779 family units are eligible to receive Prescription Drug Plan benefits.

Of these about 458,400 families are included within the deductible program, and 68,300 individuals are exempted from the deductible program, and continue to pay a low fixed co-payment, or no payment.

Population Receiving Benefits

Between April 1987 and June 1987, 453,845 individual beneficiaries received Drug Plan benefits. These beneficiaries represent 323,206 families, or 64.5% of eligible families.

Between July 1987 and March 1988, 113,610 or 22.7% of eligible families exceeded deductibles and submitted refund claims. In this same period, another 66,472 individual beneficiaries or 6.7% of the eligible population who were exempted from the deductible program received benefits through the Drug Plan.

Utilization

Between April 1987 and June 1987, each beneficiary of Drug Plan benefits received an average of 4.3 prescriptions. Between July 1987 and March 1988, each family exceeding the deductible submitted for refund an average of 11.9 prescriptions. In this same period, those individual beneficiaries exempted from the deductible program received an average of 9.6 prescriptions.

Value of Benefits Received

Between April 1987 and June 1987, each beneficiary of Drug Plan benefits received an average benefit value of $67.00. Between July 1987 and March 1988, each family exceeding the deductible received an average refund of $145.98. In this same period, those individual beneficiaries exempted from the deductible program received an average benefit value of $101.69.

Family Unit Type

Between July 1987 and March 1988, of the 113,610 family units which exceeded deductibles and submitted refund claims, 28,793 were senior families (at least one member 65 or over), 25,213 were single seniors, and 59,601 were non-senior families.

In this same period, senior families submitted for refund an average of 16.0 prescriptions, single seniors submitted an average of 11.4 prescriptions, and non-senior families submitted an average of 10.2 prescriptions.

Drugs

During the first quarter of 1987-88, the Prescription Drug Plan provided coverage for 1.96 million prescriptions for a total payment to pharmacies of $30.41 million.

During the last three quarters of 1987-88, the Prescription Drug Plan provided coverage for 1.95 million prescriptions for a total payment of $26.57 million.

Pharmacies

A total of 371 pharmacy outlets operated under agreement with the Prescription Drug Plan on March 31, 1988. Of these, 70.9% were independent pharmacies, 18.1% were chain outlets, and 5.9% were co-operative.

Table I
Prescription Drug Plan Payments

Statistical Tables		
Payments to Pharmacies (on behalf of families)		
April 1987 - June 1987[1]		
Drug Material Cost	$27,079,141	
Dispensing Fee Subsidy	3,326,742	
Sub-total April - June 1987[2]		$30,405,883
July 1987 - March 1988		
Drug Material Cost	$7,259,033	
Mark-up	730,070	
Dispensing Fee Subsidy	1,994,173	
Sub-total July 1987 - March 1988		$ 9,983,276
Total Payments to Pharmacies		$40,389,159
Payments Direct to Families (refunds)		
July 1987 - March 1988[3]		
Drug Material Acquisition Cost	$18,856,161	
Mark-up	1,678,610	
Dispensing Fee Subsidy	7,039,449	
Total Approved Cost	27,574,220	
Less Deductible Credits	6,842,997	
	20,731,223	
Less Family Co-Payment 20%	4,146,314	
Total Payments to Families		$16,584,309
Total Prescription Drug Plan Payments		$56,974,068
Manual Adjustments[4]		(373,955)
Net Payments		$56,600,113
Financial Statements		
Reimbursements to Pharmacies		
Drug Material Cost[5]		$34,707,775
Dispensing Fee Subsidies[6]		5,304,765
Net Payment to Pharmacies		$40,012,540
Reimbursements to Families		16,587,573
		$56,600,113

[1] Payments to Pharmacies during April 1987 — June 1987 refer to formulary drugs only and do not include exception drugs. All Statistical Tables do not reflect manual adjustment expenditures.

[2] Excludes Inventory Cost Allowance of $888,023 paid to June 30, 1987 to pharmacies to cover the high cost of carrying inventory.

[3] Payments to Pharmacies during July 1987 — March 1988 and direct to families refer to formulary drugs and exception status drugs.

[4] Manual adjustments include year-end adjustments made in accordance with accounting policies and other adjustments.

[5] See Statement of Revenue, Expenditure and Fund Balance page 24.

[6] Refers to dispensing fee subsidies paid by the Prescription Drug Plan. See Statement of Revenue, Expenditure and Fund Balance page 24.

Table II
Prescription Drug Plan Payments to Families

	1987 Prescriptions	1988 Prescriptions	Total
Reimbursements to Families — 1987 and 1988 Prescriptions			
Drug Material Cost (including Mark-up)	$17,286,694	$3,248,077	$20,534,771
Dispensing Fees	6,153,236	886,213	7,039,449
Total Approved Cost	23,439,930	4,134,290	27,574,220
Less: Deductibles Paid by Claiming Families	5,218,501	1,624,496	6,842,997
	18,221,429	2,509,794	20,731,223
Less Family Co-Payment 20%	3,644,355	501,959	4,146,314
Total Prescription Drug Plan Payments to Families	$14,577,074	$2,007,835	$16,584,909

Table III
Prescription Drug Utilization by Family Unit Type (Deductible Program)

Family Unit Type	Number of Family Units	Number of Prescriptions	Drug Material Cost	Approved Prescription Cost	Net Family Payments[2]	Drug Plan Payments
1987 Prescriptions						
Under 65 Family	59,627	560,985	$8,569,729	$11,490,381	$5,205,265	$6,285,116
65 and over Single	28,533	383,653	5,559,089	7,528,487	2,316,306	5,212,181
65 and over Others[1]	24,731	240,031	3,157,744	4,420,809	1,341,235	3,079,574
	2	22	132	253	50	203
1988 Prescriptions						
Under 65 Family	6,679	45,921	$1,052,322	$ 1,290,916	$ 790,545	$ 500,371
65 and over Single	8,785	77,824	1,391,821	1,792,662	853,157	939,505
65 and over Others[1]	7,218	46,861	803,721	1,050,461	482,703	567,758
	1	7	213	251	50	201
Combined 1987-1988 Prescriptions						
Under 65 Family	59,601	606,906	$9,622,051	$12,781,297	$5,995,810	$6,785,487
65 and over Single	28,793	461,477	6,950,910	9,321,149	3,169,463	6,151,686
65 and over Others[1]	25,213	286,892	3,961,465	5,471,270	1,823,938	3,647,332
	3	29	345	504	100	404

[1] Families submitting claims where, due to adjustment in family structures, a deductible was waived.

[2] Net Family Payments is the net cost to a family being the total of the deductible and the 20% not reimbursed by the Drug Plan.

Table IV
Prescription Costs to Families (Deductible Program)

Cost to Family Unit	Number of Family Units	Number of Prescriptions	Drug Material Cost	Approved Prescription Cost	Net Family Payments	Drug Plan Payments
$ 0.00 - 25.00	919	1,497	$ 7,401	$ 15,140	$ 15,057	$ 83
25.01 - 50.00	18,618	107,012	859,155	1,414,945	722,628	692,317
50.01 - 75.00	35,736	262,433	2,853,495	4,215,886	2,325,910	1,889,976
75.01 - 100.00	26,000	271,480	3,574,134	4,984,932	2,198,227	2,786,705
100.01 - 125.00	9,668	140,865	2,219,848	2,953,257	1,054,750	1,398,507
125.01 - 150.00	5,438	93,185	1,588,072	2,072,696	722,676	1,350,020
150.01 - 175.00	3,851	80,032	1,337,650	1,755,314	605,622	1,149,692
175.01 - 200.00	2,821	68,497	1,151,419	1,505,557	511,023	994,534
200.01 - 225.00	2,451	63,590	1,128,918	1,457,820	504,333	953,487
225.01 - 250.00	2,144	58,230	1,075,464	1,378,392	495,845	882,547
250.01 - 275.00	1,744	51,898	1,005,143	1,274,439	444,130	830,309
275.01 - 300.00	1,276	39,906	842,033	1,047,934	355,172	692,762
300.01 - 400.00	2,303	85,597	1,994,367	2,438,311	751,412	1,686,899
400.01 - 500.00	504	23,372	647,280	768,480	209,824	558,656
500.01 and over	137	7,710	250,392	291,117	72,702	218,415
All	113,610[2]	1,355,304	$20,534,771	$27,574,220	$10,989,311[1]	$16,584,909

[1] Net Family Payments is the net cost to a family being the total of the deductible and the 20% not reimbursed by the Drug Plan.

[2] 21,966 families submitted claims for 1987 and 1988 on or before March 31, 1988, therefore incurring two deductibles, up to 62.50 for 1987 (half year) and up to $125.00 for 1988 full year.

Table V
Prescription Costs to Families (Payments to Pharmacies)

Cost to Family (Consumer Cost)	Number of Active Families	Number of Prescriptions	Drug Material Cost	Drug Plan Payment	Total Family Payments (Consumer Cost)	Credits to Pharmacies
April-June 1987 (as billed by pharmacies on behalf of all beneficiaries)						
$ 0.01 - 10.00	133,702	287,496	$ 3,361,241	$ 4,126,764	$ 684,152	$ 4,810,916
10.01 - 20.00	85,035	360,699	4,698,131	5,262,410	1,271,384	6,533,794
20.01 - 30.00	31,748	231,471	3,160,482	3,514,751	801,487	4,316,238
30.01 - 40.00	27,228	260,083	3,626,428	4,020,357	951,724	4,972,081
40.01 - 50.00	12,762	159,601	2,315,819	2,556,574	575,742	3,132,316
50.01 - 60.00	11,723	173,001	2,505,025	2,766,273	643,396	3,409,669
60.01 - 70.00	5,739	100,938	1,473,012	1,625,800	372,712	1,998,512
70.01 - 80.00	5,360	105,988	1,561,272	1,721,770	400,163	2,121,933
80.01 - 90.00	2,590	58,869	900,869	989,750	219,526	1,209,276
90.01 - 100.00	2,502	62,242	940,846	1,035,419	236,737	1,272,156
100.01 - 150.00	3,908	120,938	1,844,561	2,029,142	459,238	2,488,380
150.01 - 200.00	749	32,784	525,500	576,036	125,013	701,049
200.01 - 300.00	147	8,529	144,466	157,430	32,863	190,293
300.01 - 400.00	9	841	14,129	15,326	3,003	18,329
400.01 - 500.00	4	459	7,360	8,081	1,748	9,829
500.01 and over	—	—	—	—	—	—
	323,206	1,963,939[1]	$27,079,141	$30,405,883	$6,778,888	$37,184,771
July 1987-March 1988 (as billed by pharmacies on behalf of deductible exempted beneficiaries)						
$ 0.01 - 10.00	29,065	248,506	$ 3,263,155	$ 4,472,208	$ 75,428	$ 4,396,779
10.01 - 20.00	6,111	63,577	800,999	1,003,875	91,999	911,876
20.01 - 30.00	2,806	40,958	559,285	681,066	70,525	610,542
30.01 - 40.00	1,966	31,604	435,802	522,901	69,480	453,421
40.01 - 50.00	1,136	21,242	312,455	368,852	51,114	317,738
50.01 - 60.00	1,012	19,965	282,249	329,663	55,842	273,821
60.01 - 70.00	709	16,032	225,382	261,361	46,141	215,219
70.01 - 80.00	742	17,242	238,708	274,626	55,717	218,909
80.01 - 90.00	454	12,055	157,128	182,784	38,578	144,206
90.01 - 100.00	561	14,662	206,700	232,215	53,152	179,063
100.01 - 150.00	1,499	48,113	659,023	734,817	183,007	551,810
150.01 - 200.00	724	30,821	424,144	467,214	123,627	343,588
200.01 - 300.00	374	21,250	305,352	332,905	87,934	244,971
300.01 - 400.00	56	4,086	71,991	75,344	18,880	56,464
400.01 - 500.00	15	935	25,354	24,012	6,449	17,563
500.01 and over	8	504	21,376	19,433	4,713	14,719
	47,238	591,552[2]	$ 7,989,103	$ 9,983,276	$1,032,586	$ 8,950,689

[1] Refers only to formulary drugs.

[2] Refers to formulary drugs and exception status drugs.

Table VI
Prescription Drug Utilization by Age and Sex of Consumer (Payments to Pharmacies)

Age of Consumer	Active Beneficiaries	Number of Prescriptions	Drug Material Cost	Drug Plan Payment
April - June 1987 (as billed by pharmacies on behalf of all beneficiaries)				
Male				
0 - 4	18,928	39,609	$ 351,940	$ 429,894
5 - 14	21,239	44,692	606,405	687,634
15 - 24	21,479	49,507	586,060	679,023
25 - 34	24,460	63,768	875,909	992,545
35 - 44	20,248	67,934	1,036,232	1,158,016
45 - 54	18,466	82,903	1,367,817	1,509,344
55 - 64	23,081	136,815	2,261,589	2,490,018
65 - 74	22,028	154,390	2,372,393	2,608,091
75 - 84	13,122	101,965	1,383,279	1,544,151
85 and over	3,557	27,558	298,108	349,259
Male Total	186,608	769,141	$11,139,732	$12,447,975
Female				
0 - 4	17,319	33,681	$ 274,313	$ 341,291
5 - 14	21,408	41,344	481,988	558,877
15 - 24	44,627	118,558	1,680,519	1,892,333
25 - 34	45,847	133,313	1,926,317	2,156,590
35 - 44	27,808	103,952	1,445,721	1,622,594
45 - 54	24,924	126,483	1,755,247	1,964,133
55 - 64	29,470	186,315	2,641,175	2,943,685
65 - 74	30,139	230,039	3,138,988	3,491,326
75 - 84	19,005	163,901	2,038,311	2,306,219
85 and over	6,690	57,212	556,830	680,860
Female Total	267,237	1,194,798	$15,939,409	$17,957,908
Both Sexes				
0 - 4	36,247	73,290	$ 626,253	$ 771,185
5 - 14	42,647	86,036	1,088,392	1,246,511
15 - 24	66,106	168,065	2,266,579	2,571,356
25 - 34	70,307	197,081	2,802,227	3,149,135
35 - 44	48,056	171,886	2,481,953	2,780,610
45 - 54	43,390	209,386	3,123,064	3,473,477
55 - 64	52,551	323,130	4,902,764	5,433,703
65 - 74	52,167	384,429	5,511,381	6,099,417
75 - 84	32,127	265,866	3,421,590	3,850,370
85 and over	10,247	84,770	854,938	1,030,119
Grand Total	453,845	1,963,939	$27,079,141	$30,405,883[1]

[1] Excludes Inventory cost allowances and exception status drugs.

Table VI (Continued)

Prescription Drug Utilization by Age and Sex of Consumer (Payments to Pharmacies)

Age of Consumer	Active Beneficiaries	Number of Prescriptions	Drug Material Cost	Drug Plan Payment
July 1987 - March 1988 (as billed by pharmacies on behalf of all deductible exempt beneficiaries)				
Male				
0 - 4	3,509	13,134	$ 110,659	$ 174,480
5 - 14	3,017	11,094	164,698	213,306
15 - 24	3,243	18,119	264,004	338,343
25 - 34	3,190	25,553	388,201	484,371
35 - 44	2,470	24,029	404,143	493,967
45 - 54	2,174	24,524	375,162	463,893
55 - 64	2,928	36,825	593,957	721,039
65 - 74	2,238	26,768	422,449	493,537
75 - 84	2,156	33,036	425,796	507,167
85 and over	1,385	26,200	279,207	348,258
Male Total	26,310	239,282	$ 3,428,276	$ 4,238,361
Female				
0 - 4	3,231	11,161	$ 85,047	$ 140,677
5 - 14	3,372	12,705	168,047	221,871
15 - 24	6,515	31,782	447,673	579,602
25 - 34	5,388	36,654	533,185	667,191
35 - 44	2,907	27,225	378,595	478,835
45 - 54	2,247	27,510	401,174	506,686
55 - 64	2,632	36,862	569,981	702,434
65 - 74	2,454	35,209	521,775	619,965
75 - 84	3,231	60,802	743,368	904,617
85 and over	3,522	72,360	711,982	923,037
Female Total	35,499	352,270	$ 4,560,827	$ 5,744,915
Both Sexes				
0 - 4	6,740	24,295	$ 195,706	$ 315,157
5 - 14	6,389	23,799	332,745	435,177
15 - 24	9,758	49,901	711,677	917,945
25 - 34	8,578	62,207	921,386	1,151,562
35 - 44	5,377	51,254	782,738	972,802
45 - 54	4,421	52,034	776,336	970,579
55 - 64	5,560	73,687	1,163,938	1,423,473
65 - 74	4,692	61,977	944,224	1,113,502
75 - 84	5,387	93,838	1,169,164	1,411,784
85 and over	4,907	98,560	991,189	1,271,295
Grand Total	61,809	591,552	$ 7,989,103[1]	$ 9,983,276[1]

[1] Includes exception status drugs, and mark-up on drug acquisition cost.

Table VII
Prescription Drug Use by Type of Beneficiary (Payments to Pharmacies)

Type of Beneficiary	Active Beneficiaries[1]	Number of Prescriptions	Total Drug Plan Payment
April - June 1987			
Standard Beneficiaries	420,594	1,811,051	$27,938,452
Saskatchewan Assistance Plan Recipients			
– Prescription Charge Subsidized (Plan One)	15,844	61,861	965,120
– Prescription Charge Fully Covered			
Special Drugs for Plan One	4,086	8,616	177,641
Dependents of Plan One to Age 18	8,963	18,284	264,620
Plans Two and Three	7,459	56,066	883,794
Special Beneficiaries			
– Paraplegics	662	4,468	95,267
– Cystic Fibrosis	88	559	14,760
– Chronic Renal Disease	240	3,026	65,949
– Other	1	8	280
Total	457,937	1,963,939	$30,405,883[2]
July 1987 - March 1988			
Standard Beneficiaries[3]	11,506	98,712	$ 1,570,927
Saskatchewan Assistance Plan Recipients			
– Prescription Charge Subsidized (Plan One)	18,604	115,167	1,878,050
– Prescription Charge Fully Covered			
Special Drugs for Plan One	4,977	22,311	395,353
Dependents of Plan One to Age 18	12,903	40,778	542,097
Plans Two and Three	9,530	140,841	2,363,574
Special Beneficiaries			
– Paraplegics	766	12,479	283,282
– Cystic Fibrosis	100	1,770	95,885
– Chronic Renal Disease	289	9,638	417,702
Nursing Home Residents	6,644	135,643	1,751,811
Special Drug Coverage	808	11,155	311,541
Palliative Care	225	2,511	98,756
Special Drugs	120	547	274,298
Total	66,472	591,552	$ 9,983,276[4]

[1] Total does not equal this column because a beneficiary may be covered in more than one category during the fiscal year.

[2] Excludes Inventory Cost Allowance and exception status drugs.

[3] Beneficiaries for whom insulin, testing agents, and provisional special drug coverage claims were paid.

[4] Includes exception status drugs, and mark-up on drug acquisition cost.

Table VIII
Prescriptions by Pharmacologic Therapeutic Classification (Payments to Pharmacies)

Pharmacologic — Therapeutic Classification[1]		Number of Prescriptions	Drug Material Cost	Total Drug Plan Payment
April - June 1987 (as billed by pharmacies on behalf of all beneficiaries)				
8:00	Anti-Infectives	282,514	$ 2,298,022	$ 2,788,319
12:00	Autonomic Drugs	73,501	1,268,595	1,399,917
20:00	Blood Formation and Coagulation	7,239	90,066	101,594
24:00	Cardiovascular Drugs	402,893	6,352,176	6,973,434
28:00	Central Nervous System Drugs	449,318	6,283,221	7,070,306
36:00	Diagnostic Agents	15,438	471,418	498,412
40:00	Electrolytic, Caloric and Water Balance	147,548	1,315,109	1,555,136
48:00	Cough Preparations	65	2,665	2,902
52:00	Eye, Ear, Nose and Throat Preparations	76,305	920,196	1,044,848
56:00	Gastrointestinal Drugs	68,861	1,756,804	1,868,985
60:00	Gold Compounds	1,202	81,751	83,583
64:00	Metal Antagonists	1,290	46,145	48,090
68:00	Hormones and Substitutes	218,927	2,886,846	3,296,144
76:00	Oxytocics	72	297	421
84:00	Skin and Mucous Membrane Preparations	110,024	1,413,928	1,599,709
86:00	Spasmolytics	26,020	346,085	391,029
88:00	Vitamins	15,067	82,116	108,604
92:00	Unclassified	46,441	1,131,054	1,206,239
	Extemporaneous Preparations	21,214	332,647	368,211
Total		1,963,939[3]	$27,079,141	$30,405,883[2]
July 1987 - March 1988 (as billed by pharmacies on behalf of deductible exempted beneficiaries)				
8:00	Anti-Infectives	69,075	$ 553,646	$ 854,430
12:00	Autonomic Drugs	24,137	369,157	464,453
20:00	Blood Formation and Coagulation	2,109	37,902	44,090
24:00	Cardiovascular Drugs	62,040	966,799	1,155,360
28:00	Central Nervous System Drugs	152,924	1,795,392	2,365,476
36:00	Diagnostic Agents	23,489	620,490	609,072
40:00	Electrolytic, Caloric and Water Balance	36,246	155,781	268,578
48:00	Cough Preparations	70	3,162	3,545
52:00	Eye, Ear, Nose and Throat Preparations	13,641	152,452	204,278
56:00	Gastrointestinal Drugs	20,939	505,680	580,878
60:00	Gold Compounds	180	11,057	11,078
64:00	Metal Antagonists	240	22,814	23,538
68:00	Hormones and Substitutes	130,391	1,561,401	1,962,175
76:00	Oxytocics	39	155	301
84:00	Skin and Mucous Membrane Preparations	24,725	306,917	406,809
86:00	Spasmolytics	7,697	118,530	147,879
88:00	Vitamins	5,232	27,128	46,486
92:00	Unclassified	18,378	780,640	834,850
Total		591,552[4]	$ 7,989,103	$ 9,983,276[5]

[1] The drug classification system used is that of the American Society of Hospital Pharmacists.

[2] Excludes Inventory Cost Allowance paid to pharmacies to June 30, 1987.

[3] Refers only to formulary drugs.

[4] Refers to formulary drugs and exception status drugs.

[5] Includes mark-up on drug acquisition cost after June 30, 1987.

Table IX
Prescriptions by Pharmacologic Therapeutic Classification (Deductible Program)

Pharmacologic — Therapeutic Classification[1]		Number of Prescriptions	Drug Material Cost	Approved Prescription Cost[2]
July 1987 - March 1988				
8:00	Anti-Infectives	172,123	$ 1,382,071	$ 2,290,435
12:00	Autonomic Drugs	58,007	1,108,963	1,410,810
20:00	Blood Formation and Coagulation	8,340	146,371	189,478
24:00	Cardiovascular Drugs	390,579	7,340,904	9,359,464
28:00	Central Nervous System Drugs	306,320	4,339,389	5,930,765
36:00	Diagnostic Agents	149	4,012	4,416
40:00	Electrolytic, Caloric and Water Balance	87,631	385,119	838,516
48:00	Cough Preparations	31	1,006	1,160
52:00	Eye, Ear, Nose and Throat Preparations	45,786	620,262	858,972
56:00	Gastrointestinal Drugs	48,143	1,293,969	1,543,316
60:00	Gold Compounds	1,058	72,786	78,291
64:00	Metal Antagonists	1,227	47,653	53,953
68:00	Hormones and Substitutes	107,256	1,495,351	2,049,633
76:00	Oxytocics	22	94	208
84:00	Skin and Mucous Membrane Preparations	50,072	670,725	932,243
86:00	Spasmolytics	22,762	329,540	447,526
88:00	Vitamins	7,675	46,804	86,420
92:00	Unclassified	48,123	1,249,752	1,498,614
Total		1,355,304[2]	$20,534,771	$27,574,220[3]

[1] The drug classification system used is that of the American Society of Hospital Pharmacists.

[2] Refers only to prescription receipts submitted on family claims for formulary drugs and exception status drugs.

[3] Includes mark-up on drug acquisition cost after June 30, 1987.

Table X
Pharmacies by Location

Location of Pharmacy	Number of Pharmacies[1]
Single Pharmacy Communities	90
2 – 5 Pharmacy Communities	73
Communities With More Than 5 Pharmacies	
Moose Jaw	12
North Battleford	7
Prince Albert	14
Regina	49
Saskatoon	56
Swift Current	9
Weyburn	6
Yorkton	8
Dispensing Doctors	14
Border Pharmacies	33
Total	371

[1] Includes all pharmacies operating under agreement with the Prescription Drug Plan on March 31, 1988.

Table XI
Pharmacies by Type of Ownership

Type of Ownership	Pharmacies[1] Number	Percent
Independent	263	70.9
Chain[2]	67	18.1
Co-operatives	22	5.9
Dispensing Doctor	14	3.8
Hospital Outpatient	5	1.3
Total	371	100.0

[1] Includes all pharmacies operating under agreement with the Prescription Drug Plan on March 31, 1988

[2] Defined as common ownership of four or more stores.

Saskatchewan Prescription Drug Fund
Financial Statements
Year Ended March 31, 1988

Balance Sheet (Unaudited)
March 31, 1988

Statement 1

Assets	
Current	
Account Receivable — Pharmacy Advances	$ 376,300
Liabilities and Fund Balance	
Liabilities	
Bank Overdraft	$ 46,591
Drug Cost Advances — Health Agencies	196,468
Total Liabilities	243,059
Fund Balance (Statement 2)	133,241
	$ 376,300

Statement of Revenue, Expenditure and Fund Balance (Unaudited)
Year Ended March 31

Statement 2

	1988	1987
Operating Revenue:		
Grant — Department of Health	$59,453,000	$82,633,923
Other	2,619	3,894
	$59,455,619	$82,637,817
Operating Expenditure:		
Reimbursements:		
Drug Material Cost	$34,707,775	$67,162,035
Special Status Drugs	784,165	2,195,150
Oxygen	971,861	1,290,334
Dispensing Fee Subsidies	5,304,765	9,527,467
Inventory Cost Allowance	888,023	2,418,769
Drug Cost Advances (Recoveries)		(104,987)
Patient Claims	16,587,573	—
Other	78,216	79,850
	$59,322,378	$82,568,618
Surplus (deficit) for the year	$ 133,241	$ 69,199
Fund balance, beginning of year	—	(65,305)
Other revenue transferred to consolidated	—	(3,894)
Fund balance, end of year	$ 133,241	$ —